



OFFICE: 678.381.2020 FAX: 678.381.2015

ALPHARETTA | BUFORD | CANTON | CUMMING | DAWSONVILLE | JOHNS CREEK | MARIETTA | SNELLVILLE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Completed form can be faxed to 678-381-2015 or emailed to medicalrecords@milaneyecenter.com

Our mailing address is: **Medical Records Dept., 1034 Haw Creek Circle, Ste 100, Cumming, GA 30041**

Patient Name: _____ **DOB:** _____

I, _____ authorize Milan Eye Center to disclose a copy of my medical records

as identified below to (name / address / phone / fax): _____

_____ for the following purposes:

- ☐ Continuing Care & Treatment ☐ Insurance Claim ☐ Legal ☐ Personal Use
☐ Other (describe): _____

By initialing the spaces below, I specifically authorize the use and disclosure of the following health information and/or medical records, if such information and/or medical records exist:

- ☐ Discharge Summary/Discharge Note ☐ Examinations ☐ Consultation Reports
☐ Diagnostic Imaging Reports ☐ Progress Notes ☐ Physician Orders
☐ Laboratory Reports ☐ Entire Medical Record ☐ Other (describe): _____

I understand that if the person or entity receiving the information is not a health care provider or health care plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I understand that the person I am authorizing to use or disclose the information may receive compensation for doing so. I may inspect or copy any information to be used or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signature or until _____.

Signature of Patient or Patient's Legal Representative

Date

Patient's name (PLEASE PRINT)

Name of Patient's Legal Representative (PLEASE PRINT)

Relationship